Non-Reportable List

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 20. Upon review of the disease index, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (173.0-9) (excluding genital sites), and CIN of the cervix (233.1). A list of these cases must be kept each year because the TCR needs to review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 11). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 33) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used. If cases are abstracted and reported using SCL v.10, a non-reportable log may be kept. Please refer to the *SCL User's Guide* for instructions.

Examples:

a. The ICD-9-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. **This case is not reportable, unless the physician states the patient has active, metastatic, or recurrent disease.**

b. Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. **This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.**

c. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. **This case is not reportable because the patient has a history of cancer with no evidence of active disease.**

d. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. **This case is not reportable because there is no indication that the patient has current disease.**

e. A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. **This case is not reportable because there is not information regarding whether the patient has current lung cancer.**